AMERICAN SOCIETY OF PLASTIC SURGEONS
PLASTIC SURGERY EDUCATIONAL FOUNDATION

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April 30, 2011

Honorable Fred Upton
Chairman, Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Representative Upton:

On behalf of the American Society of Plastic Surgeons (ASPS), I write to respond to your request for input on the Medicare Physician Payment system. ASPS appreciates the opportunity to share our views, and thanks you and the other members of the committee for your focus on this important issue. The current Medicare physician payment system as a whole, and specifically the Sustainable Growth Rate (SGR), has increasingly resulted in severe instability for physician practices and less access to care for Medicare beneficiaries. Further, a series of patchwork "fixes" in recent years have delayed a permanent solution to this problem and introduced more distortions in the system. This situation has also resulted in vastly increasing the cost of a solution. We urge Congress to immediately address this problem to create a physician payment system that is stable, and to sustain the program for our nation's senior citizens.

Medicare Physician Payment System – Sustainable Growth Rate (SGR)

It need not be repeated here that the SGR is a failed payment model. The system is so broken that Congress had to intervene five times last year to stop draconian cuts in physician payments that would have severely hampered beneficiary access to care. It is imperative that Congress act this year to permanently repeal the SGR.

Further, we urge Congress to incorporate a five year period of statutory updates based on the medical economic index (MEI) as part of the transition to a new Medicare physician payment system. This transition is necessary to ensure that new payment models appropriately incorporate quality care parameters and information technology into the payment calculation, and that innovative payment methodologies are appropriately tested. Physician practices must be able to determine what is best for their patients as they incorporate new systems and processes into their business models.

However, there is no one size fits all model. Some practices have limitations on their ability to incorporate newer models due to patient population, geography or other demographic limitations. These new models of clinical integration also require data infrastructure, staff to collect data, staff skilled in analyzing data, and applying it for evidence based practice as well as the ability to share information and coordinate care.

Additionally, emerging shared savings models often require investments without initial rewards thus requiring significant cash reserves. Not all physician practices are prepared to quickly move to a new payment system that rewards these activities. For some practices, it may be necessary to remain in a traditional fee for service Medicare model. For others, accountable care organizations (ACOs) and other innovative practice models may work, but a transition period is needed so that these models may be appropriately tested across a broad variety of physician practice types. Finally, for many innovative payment models, existing antitrust and anti-kickback statutes must be amended to allow for appropriate coordination in local communities.

Recommendation

We urge Congress to ensure that any new system is based on flexibility to accommodate differences in practice types and capability, and to avoid application of one payment model to all physician practices. Additionally, Congress should enact a 5 year transition period to allow for proper testing of these models across the country, before a new system is incorporated into Medicare. During the transition, Congress should ensure statutory updates based on the MEI.

- **Service Category Growth Targets**

The SGR experiment has shown that a national target for reducing the rate of growth of Medicare Part B services is ineffective and unrealistic. ASPS believes that because different sectors of medicine grow at different rates, a more realistic payment system would include multiple growth targets for different service categories based on rate of growth analysis. For example, there has not been a substantial increase in the volume of surgical procedures in the Medicare program, yet the volume target for increased utilization applies to all physicians. We urge Congress to consider establishing a payment system with multiple growth targets to provide a bridge to future alternative payment models. Multiple targets will better allow fine tuning of efforts to identify and promote or slow the use of specific services. Such a system would also allow quality incentive programs to be more targeted, and better reflect differences in the way various types of services are provided.

- **Breaking Down Medicare Silos**

As the patient care system in our country has become more reliant on evidence based guidelines, and as technology has improved, many conditions that were previously dealt with in the hospital can now be handled in physician practices and Ambulatory Surgery Centers (ASCs). This has resulted in, and will continue to result in, savings to the system that are not currently accrued to Medicare Part B due to separate payment systems for different sectors of Medicare. We believe that the Medicare budget needs to be viewed on a more holistic basis and that breaking down the silos, particularly between Parts A and B, needs to be part of developing a new payment system for the future of Medicare.

- **Independent Medicare Payment Advisory Board (IPAB)**

ASPS strongly opposes the Independent Medicare Payment Advisory Board (IPAB). While the IPAB is not part of the current Medicare Payment system, our comments do not occur in a vacuum, and a body with the potential for such an enormous impact on the Medicare program can not be ignored.

Medicare payment policy requires a broad and thorough analysis of the affects on all providers and beneficiaries. The IPAB solution will arbitrarily ratchet down provider reimbursement, without sufficient oversight and without care taken to ensure that our seniors receive the quality health care that they need and deserve. As currently constructed, the Board does not have full authority over all aspects of the health care system, but rather is required to selectively exempt certain providers from its purview, placing more pressure to cut Medicare in those areas under its jurisdiction. We do not support allowing important health care decisions to be made by individuals with little or no clinical expertise, resources, oversight or the accountability required to ensure that seniors are not placed in jeopardy.

We recognize the importance of lowering health care costs and we are committed to improving the value of health care. However, the IPAB is not a suitable mechanism to achieve these goals. Leaving Medicare payment decisions in the hands of an unelected, unaccountable governmental body with minimal congressional oversight will negatively affect timely access to quality health care for our country's senior citizens and the disabled. The arbitrary reduction of Medicare physician payments under such a scenario carries the threat of undoing movement to more innovative payment systems, and could have a chilling effect on beneficiary access to care.

Preserving the Physician – Patient Relationship

Under the current Medicare program, patients do not have the right to contract with the physicians outside of Medicare. Physicians who enter even one agreement with a patient to provide services outside of Medicare are legally excluded from the Medicare program for two years. Additionally, the beneficiary gets no reimbursement from Medicare under such a scenario – even if the benefits would otherwise be a partially covered benefit.

ASPS plans to support new legislation to allow these arrangements without penalizing physicians, and to allow the beneficiary to recoup the portion of the payment Medicare would otherwise cover. The legislation will include appropriate and important beneficiary protections. We urge Congress to include these provisions in any new physician payment system.

Medical Liability Reform

The Congressional Budget Office (CBO) has recognized the steep cost of our current liability system in scoring approximately $40 billion in savings from comprehensive medical liability reform. The current system for compensating injured patients drives defensive medicine practices in health care and increases health care costs. Additionally, access to care for high risk procedures is increasingly compromised by lawsuit abuse. We urge Congress to enact meaningful liability reform such as that in H.R. 5, the HEALTH Act.

Quality Improvements

ASPS has undertaken multiple quality improvement initiatives in recent years, and supported enactment of comparative effectiveness research legislation. ASPS also maintains a clinical outcomes database, Tracking Outcomes in Plastic Surgery (TOPS), and has long supported data-driven approaches to quality care and incentives for achieving results. The Medicare program should foster acquisition and use of reliable outcomes and clinical effectiveness data, as well as developing a reimbursement system that rewards, rather than penalizes, physicians for improved outcomes.

Building true continuous quality improvement systems is dependent upon collection, analysis, and feedback to physicians of risk-adjusted clinical outcomes and utilization data. Subsequently, clinical data can then be linked with administrative data to track the cost of care over time and provide an assessment of clinical and cost effectiveness, including new technologies and devices. Only a clinical database with a sufficient volume of clinical records can be credibly risk-adjusted for case mix to yield accurate and comparable findings – focusing on costs alone is insufficient. Claims data, without requisite clinical information, is not a meaningful approach to assessing physician quality. To be meaningful, risk adjusted quality measures must be compared to resource utilization and feedback must be provided to physicians, including non-punitive strategies to improve utilization, effectiveness, and outcomes.

Physicians, in collaboration with their professional societies, are best positioned to define what constitutes high quality care. Additionally, it is well documented that physicians can best improve quality in a non-punitive environment. However, the PPACA does just the opposite by requiring physicians to participate in the Physician Quality Reporting System (formerly the Physician Quality Reporting Initiative) or face future Medicare cuts. In addition, the PPACA directs the Secretary of the Department of Health and Human Services (HHS) to develop a new budget-neutral payment modifier to the Medicare physician fee schedule, which would be based on the relative quality and cost of care delivered. This system will ostensibly be based on a composite of risk-adjusted measures of quality, although no such system now exists, nor will it be available anytime in the near future. Finally, the requirement on HHS to publicly report data on individual physician quality and resource use is premature, given the lack of reliable risk-adjusted clinical outcomes data.

We believe Congress should mandate that HHS incentivize development of specialty and/or condition-specific, outcomes-focused clinical data registries. Additionally, Congress should fully fund the Patient Centered Outcomes Research Institute (PCORI) which is the appropriate avenue for conducting

comparative effectiveness research as the charge of PCORI focuses on clinical research, rather than cost, in an open and transparent manner.
There are several provisions in current law that should be repealed or delayed to ensure an appropriate foundation is built for quality improvement and that physicians are incentivized appropriately rather than face a punitive system: **repeal penalties for quality reporting; defer electronic prescribing and HIT penalties; repeal the budget-neutral value-based payment modifier; and delay the public reporting of physician quality and resource use measures until valid risk-adjusted clinical outcomes data is available.** We look forward to working with Congress to ensure the Medicare payment system is built on a value based foundation that appropriately incentivizes physicians and delivers the best possible patient care.

Conclusion

ASPS greatly appreciates your efforts to look seriously at the problems related to the current Medicare physician payment system, and to work to sustain access to the physician of their choice for Medicare beneficiaries. We look forward to working with you to repeal the SGR and to replace it with a more stable and rational payment system. If you need more information or any assistance from our Washington office, please contact Lori Shoaf, Director, Federal Government Affairs at 202-672-1518 or lshoaf@plasticsurgery.org.

Sincerely,

Phil Haeck, MD
President,
American Society of Plastic Surgeons

cc:

The Honorable Henry Waxman
The Honorable Joe Barton
The Honorable John Dingell
The Honorable Joe Pitts
The Honorable Frank Pallone
The Honorable Michael Burgess, MD